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REVIEW ARTICLE

Qualitative metasummary: Parents seeking support related to their TGNC children

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ABSTRACT

Background: Parents seek support on behalf of their transgender and gender nonconforming (TGNC) children. Previous qualitative studies explore the types of support parents seek inside and outside of healthcare settings. Healthcare providers often remain unprepared to effectively provide gender-affirming services to TGNC children and their accompanying parents and may benefit from learning about the support seeking experiences of parents with TGNC children.

Aims: This paper summarized qualitative research studies that address the topic of parents seeking support on behalf of their TGNC children. We produced this report for healthcare providers to review to enhance gender-affirming services for parents and TGNC children.

Methods: This paper outlines a qualitative metasummary of studies from the United States or Canada with data collected from parents of TGNC children. Data collection included the steps of journal runs, database searches, reference checks, and area scans. Data analysis involved the steps of extracting, editing, grouping, abstracting, and calculating the intensity and frequency effect sizes for finding statements from qualitative research study articles.

Results: The results of this metasummary yielded two primary themes, six subthemes, and 24 total findings. The first primary theme of seeking guidance had three subthemes: educational resources, community networks, and advocacy efforts. The second primary theme of seeking healthcare had three subthemes: healthcare providers, mental healthcare, and general healthcare.

Discussion: These findings provide information healthcare providers can use to inform their practice. These findings also highlight the importance of providers working collaboratively with parents when serving TGNC children. This article concludes with practical tips for providers.

KEYWORDS

Healthcare; parents; qualitative; systematic literature review; transgender

Introduction

This study focused on parents seeking support related to their transgender and gender nonconforming (TGNC) children in two countries within the geographical continent of North America: the United States and Canada. In the United States, approximately 0.7% of youth (ages 13–17), and 0.6% of adults (18 and older) identify as transgender (Herman et al., 2017). Youth (Weiselberg et al., 2019) and adults (Meerwijk & Sevelius, 2017) increasingly identify as transgender and seek gender-related services from healthcare providers (Lane et al., 2018).

TGNC individuals have higher rates of depression and suicidality than cisgender individuals (e.g., Connolly et al., 2016). For example, in a research study with 109 TGNC youth participants (12–18 years old), 33% met criteria for major depressive disorder associated with experiences of minority stress (Chodzen et al., 2019). In a 2015 nationwide survey with 27,715 transgender respondents, 40% reported they previously attempted suicide, which is nine times the attempted suicide rate of the general United States population (James et al., 2016). These results highlight how stigma and discrimination can impact transgender individuals' health.

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Support for TGNC children

TGNC children benefit from familial and parental support of their gender identity. Acceptance from family members, especially from parents, can protect TGNC children from health risks (e.g., Ryan et al., 2010). Parental support, specifically, can protect TGNC children from health disparities (Weiselberg et al., 2019) and minimize depressive symptoms that TGNC children may experience (Simons et al., 2013). Protective factors include accepting comments (Ryan et al., 2010) and feelings of family connectedness (Weiselberg et al., 2019). Parents can offer support, which can influence their children's health outcomes (Janicka & Forcier, 2016).

To support their TGNC children, parents often turn first to healthcare providers. TGNC children's access to medical care may depend on their parents (Riggs et al., 2020), and the views of parents often determine whether children receive treatment (Newhook et al., 2018). Parents represent gatekeepers to children's healthcare utilization (Cronin & Kelley, 2018), and TGNC children may need parental approval before receiving gender-related medical interventions.

TGNC individuals report both positive and negative experiences with healthcare providers. TGNC individuals experience positive interactions with providers who use inclusive language and negative interactions with providers who misgender them or follow transphobic practices (Baldwin et al., 2018). Approximately one-third of TGNC individuals experience negative interactions with healthcare providers (James et al., 2016), and many experience stigmatization and discrimination within healthcare settings (Bauer et al., 2015). Some parents and their TGNC youth described negative experiences, such as meeting providers who did not understand or minimized the child's need for gender affirming treatment (Gridley et al., 2016).

TGNC individuals want providers who understand their health concerns and offer a welcoming environment (Baldwin et al., 2018). Yet many healthcare providers report feeling unprepared (Poteat et al., 2013) with a lack of training to address TGNC issues (Whitman & Han, 2017).

Support for parents of TGNC children

Parents of TGNC children also need support. For example, after a parent gains awareness of their child's TGNC identity, the parent may address their child's needs while facing others' disapproval (Riley et al., 2011). As a result, they may experience guilt and self-doubt related to decisions they make on behalf of their child (Alegría, 2018). Parents of TGNC children also experience challenges such as understanding their child's unique medical needs (e.g., Hillier & Torg, 2019) and connecting with parents of other TGNC children (Wahlig, 2015). When a parent first becomes aware of their TGNC child's identity, they may not understand what is happening (Capous-Desyllas & Barron, 2017) and envision worst-case scenarios (Sharek et al., 2018).

Providers must be ready to serve parents who seek services related to their children's gender nonconforming behavior (e.g., Weiselberg et al., 2019), including parents who disagree with their children's decision to receive gender-affirming care (Dubin et al., 2020). Providers can address the parents' needs during family interviews or in a meeting with only the parents (Boivin et al., 2020). Understanding more about how parents seek support within healthcare settings may increase providers' abilities to support parents and TGNC children. Healthcare providers can also offer parents peer-support referrals, pertinent healthcare information (World Professional Association for Transgender Health, 2012), and enhance connectedness between parents and TGNC children to facilitate the children's utilization of healthcare (Taliaferro et al., 2019).

Previous literature reviews provide useful information to providers serving TGNC families. Examples include review studies on lesbian, gay, bisexual, and transgender parents seeking healthcare for their children (Shields et al., 2012), the educational needs of families with transgender children (Sharek et al., 2018), and TGNC individuals' mental healthcare experiences (White & Fontenot, 2019). Yet less is known about parents' experiences of searching for support inside and outside of healthcare settings. This qualitative metasummary explores the topic of parents seeking support for their TGNC children. This

research paper aims to produce a report providers can review to improve the services that they offer to families with TGNC children. In this paper, the term *child* represents a relational role rather than an exact development age group. Studies reviewed in this paper focus on parents with TGNC children from youth to adulthood. In this study, we explore qualitative research studies associated with the topic of parents seeking support on behalf of their TGNC children. We created this report for the intended audience of healthcare providers, especially healthcare providers new to the field of TGNC healthcare.

Methods

We, a team of eight researchers, conducted this systematic literature review study using the qualitative metasummary method created by Sandelowski and Barroso (2007). Together we reviewed scholarly articles featuring qualitative data collected from parents of TGNC children. Researchers use the qualitative metasummary method to compose a quantitative aggregation of qualitative research findings associated with a specific area of scholarly work. Metasummaries approximate the sum of findings across research reports (Sandelowski & Barroso, 2007). This approach allows researchers to identify the frequency of findings and determine patterns or themes across qualitative research studies. Unlike a qualitative metasynthesis, which provides an interpretive analysis of qualitative studies, a qualitative metasummary provides an overview of findings common across studies related to a topic (Sandelowski & Barroso, 2007). Therefore, in this qualitative metasummary, we established descriptive themes that closely represented the findings from qualitative studies we explored, rather than producing analytical themes that go beyond studies to generate interpretive constructs (e.g., Thomas & Harden, 2008).

Data collection

First, we conducted journal runs by identifying articles containing qualitative data collected from parents of TGNC children published within five academic journals: *Journal of Gay and Lesbian Mental Health, Journal of Gay and Lesbian Social Services, Journal of GLBT Family Studies, Journal of LGBT Issues in Counseling,* and the *Journal of LGBT Youth*. Second, we searched several databases (*Family & Society Studies Worldwide, Family Studies Abstracts, MEDLINE, PsychINFO, Social Work Abstract,* and *SocINDEX*) using the following terms:

- Transgender OR transsexual OR gender varian* OR gender ident* OR gender queer OR gender fluid OR gender trans* OR gender non*
- AND disclos* OR coming out OR discover* OR aware* OR realiz*
- AND parent OR caregiver OR guardian OR mom OR dad OR mother OR father
- AND counseling OR treatment OR therap* OR support OR mental OR health

The first line of search terms represents children's various gender identity labels. The second line represents terms detailing how parents learn about their child's TGNC identity. We included this line to represent the context that precedes parents seeking support on behalf of their children. The third line includes various terms describing parental figures. The fourth line represents common terms describing professional healthcare and support related options.

Third, we reviewed the references of the articles we collected to identify additional relevant articles. Fourth, we conducted area scans by reviewing related articles that did not meet our inclusion criteria yet could possibly reference other relevant articles as cited sources. Data collection resulted in the discovery of 40 relevant articles published by December 2020. Please see Figure 1 for a PRISMA chart that outlines each step of our data collection process.

In adherence to qualitative metasummary methodology (Sandelowski & Barroso, 2007), we defined inclusion criteria to clarify parameters regarding the studies we would examine. Defining clear inclusion criteria is a strategy to minimize author bias regarding preferences or expectations for qualitative research reports selected for review appraisal. Our decisions regarding inclusion criteria aligned with the aim of qualitative

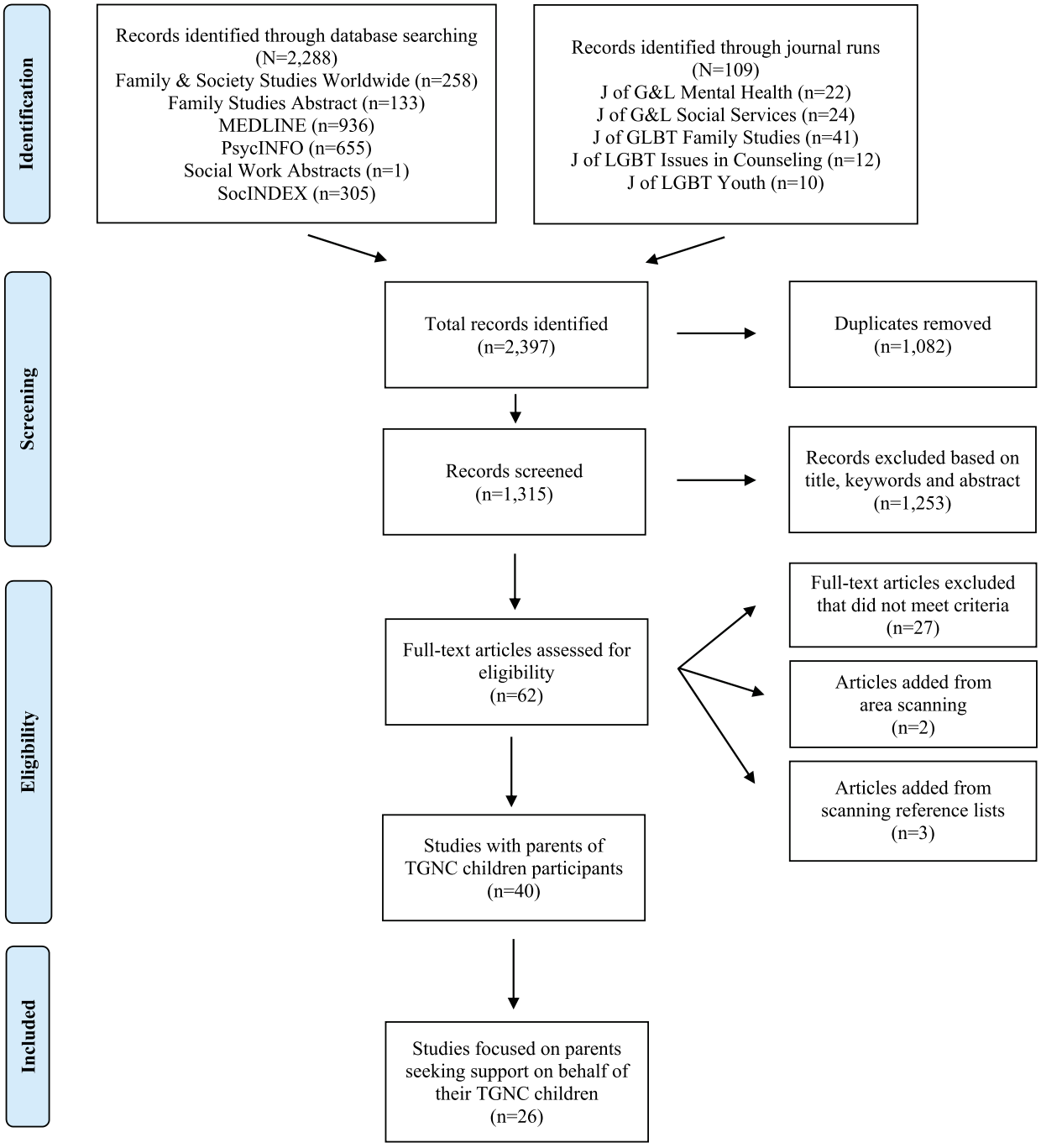

Figure 1. PRISMA flow diagram. *Note*: Use of the PRISMA flow diagram is permitted under the terms of the creative commons attribution license (Moher et al., 2009).

metasummaries to produce idiographic (i.e., case-bound) generalizations of research (Sandelowski & Barroso, 2007).

We appraised these articles to confirm whether they matched the following inclusion criteria: (1) included qualitative data from parents of TGNC children, (2) focused on parents seeking support on behalf of their TGNC child, and (3) included participants primarily from the United States of America and Canada. Treatment of TGNC individuals varies depending on geographical location. For example, researchers compared the United States and India's attitudes toward transgender individuals (Elischberger et al., 2018). They reported that each culture maintained fundamentally different conceptualizations of gender with regards to how society treats transgender individuals. To honor the diversity of global

societal contexts that exists regarding parents' efforts to receive education and healthcare for their TGNC children, we focused on only one geographical area in this study. We acknowledge that further research is necessary to explore this same topic in geographical contexts around the world. We narrowed our focus to qualitative studies with participants from the United States and Canada to create a metasummary report designed for healthcare providers in this region of the world. See Table 1 for a cross-study display of the 26 articles (published between 2006 and 2020) included in this study.

The studies we collected within this dataset did not represent TGNC child participants exclusively from two heterogenic age groups (young and adult children), but rather a spectrum age range of young children (5–8 years old, Capous-Desyllas & Barron, 2017), young adults (14–22 years old, Evans et al., 2017), and adult children (25–40 years old, Tyler, 2015). Some studies also included two age groups within the same study (4–20 years old, Sansfaçon et al., 2015). In addition, some studies also reported a spectrum age range of times when children disclosed their TGNC identities and began the process of transitioning (15–36 years old, Pearlman, 2006).

Data analysis

Data analysis involved five steps: extract, edit, group, abstract, and calculate the related intensity and frequency effect sizes. To extract our findings, we copied the results section from each article and pasted the text into a blank Microsoft Word document. Afterwards, we highlighted all of the findings that represented parental experiences of seeking support for their TGNC child. We then copied and pasted the highlighted finding statements in a document with two columns. The left column contained the original finding statements, and the right column contained edited finding statements that we created. We retained most of the authors' language and simplified the text to make each revised statement easier to compare with other statements. We placed all edited statements in a new document for the step of grouping. We continuously reviewed statements to identify similarities between them. We began to observe patterns between the finding statements, and we grouped all applicable statements into thematic categories.

For abstraction, we organized the themes, subthemes, and associated findings. This iterative process involved changing the order of themes and, at times, combining or creating new themes if additional patterns emerged. In the abstraction process, researchers reduce the number of statements into parsimonious renderings (Sandelowski & Barroso, 2007). For this step, we included findings that existed in a minimum of two peer-reviewed academic studies. By retaining findings from two separate studies, we minimized redundant findings that did not concisely or comprehensively represent our topic area. This step ended with a findings report (Table 2).

Next, we calculated the frequency and intensity effect sizes. For the intensity effect sizes, we counted the total number of findings per article and divided them by the total number of findings. For the frequency effect sizes, we counted the number of articles with each finding and divided them by the total number of included articles. We also completed steps to optimize our findings. We kept an up-to-date audit trail documenting our data collection and data analysis process. We received consultation from a researcher with expertise related to the metasummary method. We also received feedback about the usefulness of our proposed healthcare implications from a team of healthcare providers with practical experience working with TGNC individuals. These providers represented several professions (e.g., licensed clinical social workers). They offered feedback to revise our study implications for increased accessibility and utility among providers in a variety of settings (e.g., interprofessional and mental health counseling settings). In addition, we employed the strategy of negotiated consensual validation (Sandelowski & Barroso, 2007). During the data collection and data analysis process, we held weekly research team meetings and explicated our decisions. We recorded these decisions in our audit trail.

Table 1. Cross-study display

Author and year	Study purpose	Parent participants	Qualitative data	Qualitative analysis	Intensity effect size
Alegría (2018)	To explore the experiences, identities, and views of parents/caregivers of transgender children/youth.	Total: 14 Parents Gender: 12 Females, 2 Males Race/Ethnicity: 14 White Sexual Orientation: 12 Straight, 1 Gay, 1 Lesbian	In-Depth Semi-structured Interviews	Constant Comparative Method	21%
Bull & D'Arrigo-Patrick (2018)	To take account of how participants' lived experiences interacted with dominant discourses.	Total: 8 Parents Gender: 7 Cisgender Females, 1 Trans Male Race/Ethnicity: 8 White Sexual Orientation: 3 Heterosexual, 5 LGQ	Semi-structured, Open-ended, & Face-to-face Interviews	Phenomenology	8%
Capous-Desyllas & Barron (2017)	To understand the various strengths and challenges experienced by transgender children and their families within various social and cultural institutions, and the ways in which they navigate these barriers.	Total: 7 Parents Age: 41-50 Gender: 3 Female, 4 Male Race/Ethnicity: 1 Anglo-American, 1 Ecuadorian, 1 European, 1 Hispanic, 2 White, 1 Japanese & Irish	Interviews, Observations, & Document Collection	Case-study & Ethnographic Methods	13%
Clark et al. (2020)	To explore how transgender (trans) youth and parents of trans youth made decisions around hormone therapy initiation as well as trans youth experiences of barriers to care.	Total: 15 Parents	Semi-structured Interviews	Grounded Theory	46%
Evans et al. (2017)	To assess the questions transgender youth and their caregivers have about transgender health, what online resources they are currently utilizing to acquire information on this topic, and to identify potential deficits or inconsistencies that exist in the resources they are finding.	Total: 50 Caregivers Age: 29-71 Gender: 40 Females, 7 Males, 1 Trans-masculine, 2 Did Not Answer Race/Ethnicity: 39 White, 2 Black/African American, 2 Native American/American Indian or Alaska Native, 1 Hispanic/Latino(a), 2 Asian/ Pacific Islander, 4 More Than One Race/Identity	Qualitative Interviews, Focus Groups, & an Online Survey	Thematic Analysis	25%
Field & Mattson (2016)	To report the differences parents of transgender children perceive between their own experiences and those of parents of GLB children and to analyze the similarities they share with those parents.	Total: 14 Parents Age: 51-74 Gender: 11 Females, 3 Males Sexual Orientation: 14 Heterosexual	In-person, Phone, & Internet Video Chat Interviews	Coding for Themes	4%
Gonzalez et al. (2013)	To build upon previous studies by specifically asking parents to reflect on the positive experiences of being the parent of an LGBTQ individual and to gather and thematically analyze data on these positive experiences.	Total: 9.1% Subsample of Parents of Transgender Children	Online Survey, Open-ended Question	Thematic Analysis	13%
Gray et al. (2016)	To describe the experience of parenting a gender variant child, as well as the mutual influence between the child, the family, and the environment.	Total: 11 Parents Age: 37-48 Gender: 8 Cisgender Females, 3 Cisgender Males Race/Ethnicity: 11 White Sexual Orientation: 11 Heterosexual	Semi-structured In-person Interviews	Grounded Theory Analysis	38%
Gridley et al. (2016)	To identify barriers to accessing gender-affirming health care and solicit recommendations from transgender youth and their caregivers for overcoming these barriers.	Same as Evans et al. (2017)	Same as Evans et al. (2017)	Same as Evans et al. (2017)	25%
Hidalgo & Chen (2019)	To examine gender minority stress experiences among a sample of parents of transgender/gender-expansive prepubertal children who participated in focus groups of a larger study focused on how, if at all, emotional and behavioral problems of childhood are uniquely expressed by their transgender/gender-expansive children.	Total: 40 Parents Age: 42 Years (Average) Gender: 25 Females, 15 Males Race/Ethnicity: 32 White, 2 Black, 5 Hispanic/ Latino, 1 Asian	Focus Groups	Content Analysis	4%

(*Continued*)

Table 1. Continued

Author and year	Study purpose	Parent participants	Qualitative data	Qualitative analysis	Intensity effect size
Hill & Menvielle (2009)	To identify how parents with gender-variant offspring understand their child's gender and react; to identify the cognitive and emotional paths traversed by parents before the youth articulates a trans, gay, queer or heterosexual identity; and to identify how parents resist or accept various future possibilities as the youth develops in a gender non-conforming way.	Total: 42 Parents Age: 22-61 Race/Ethnicity: Black, White, Hispanic, Jewish, & Multiracial	Semi-structured, Open-ended Interviews	Grounded Theory Analysis	17%
Johnson et al. (2014)	To explore the experiences, perceptions, support systems, and coping strategies on which parents of youth who identify as transgender rely.	Total: 7 Parents Parent Type: 6 Mothers, 1 Grandmother Race/Ethnicity: 7 White	Recorded Interviews	Consensual Qualitative Research Methodology	46%
Johnson & Benson (2014)	To explore one middle-class, white mother's experiences of raising a transgender child as well as her perceptions and experiences of therapeutic services.	Total: 1 Parent Age: 40 Gender: Female Race/Ethnicity: White	Online Chat Interview Sessions & Email Correspondence	Single-case Study	33%
Katz-Wise, Budge, Fugate, et al. (2017)	To conceptualize pathways of transgender identity development using narratives from both transgender and gender nonconforming youth and their cisgender caregivers.	Total: 29 Caregivers Age: 47 Years (Average) Gender: 17 Cisgender Mothers, 11 Cisgender Fathers, 1 Grandmother Race/Ethnicity: 22 White, 1 Hispanic/Latino, 6 Multiracial/Other Sexual Orientation: 24 Straight, 2 Bisexual, 2 Lesbian/Gay, 1 Other	Semi-structured Interviews	Immersion/ Crystallization & Template Organizing Style Approaches	8%
Katz-Wise, Budge, Orovecz et al. (2017)	To examine how TGN youth and their caregivers perceive the youth's future in light of the youth's transgender identity.	Same as Katz-Wise, Budge, Fugate et al. (2017)	Same as Katz-Wise, Budge, Fugate et al. (2017)	Grounded Theory	13%
Kuvalanka et al. (2014)	To understand the experiences of parents with transgender and gender-nonconforming children and how the various contexts in which they live facilitate or inhibit their affirmation of their children's gender identities and expressions (i.e., the children's true gender selves).	Total: 5 Parents Age: 34-55 Gender: 5 Females Race/Ethnicity: 5 White or Caucasian Sexual Orientation: 5 Heterosexual	In-depth, One-on-one Telephone Interviews	Thematic Analysis	29%
Menvielle & Hill (2010)	To explore a preliminary process evaluation of an affirmative intervention with families affected by gender identity disorder in children and adolescents and to document the activities of an affirmative program and the psychological processes involved rather than its ultimate impact.	Same as Hill & Menvielle (2009)	Same as Hill & Menvielle (2009)	Same as Hill & Menvielle (2009)	50%
Newcomb et al. (2018)	To understand more about the specific practices used by parents to prevent negative sexual health outcomes in their LGBTQ teens in order to inform the development of family-based sexual health programs.	Total: Unspecified Subsample of Parents of TGNC Adolescents	Focus Groups/Online Forums	Thematic Analysis	21%
Pearlman (2006)	To explore 18 mothers' experiences of accepting a life-altering change: perceiving and responding to their child, who was once female and a daughter, as a male and a son or as gender ambiguous, or presenting as both female and male.	Total: 18 Parents Gender: 18 Females Race/Ethnicity: 18 Caucasian Sexual Orientation 17 Heterosexual, 1 Non-Heterosexual	In-person & Mail Interviews	Thematic Analysis	8%

(*Continued*)

Table 1. Continued

Author and year	Study purpose	Parent participants	Qualitative data	Qualitative analysis	Intensity effect size
Pyne (2016)	To focus a lens on parents of gender non-conforming children who affirm their children's felt sense of gender; explore how these parents come to know their children's gender identities; and develop a theory to better understand the knowledge underlying the decision to affirm the children's self-identities.	Total: 15 Parents Gender: 12 Females, 3 Males Race/Ethnicity: 1 Mixed Race, 1 First Nations, 1 Latina/o, 1 Japanese French Canadian, 1 White/Jewish, 10 White Sexual Orientations: 8 Heterosexual, 2 Queer, 2 Lesbian, 3 Bisexual or Pansexual	Semi-structured Interviews	Grounded Theory	21%
Rahilly (2015)	To illuminate the ways in which parents of significantly gender-nonconforming children come to an awareness of the gender binary as a limited cultural ideology, or a truth regime, and in turn devise various practical and discursive strategies to navigate that regime and accommodate their children's nonconformity.	Total: 24 Parents Race/Ethnicity: 23 White, 1 Non-White Sexual Orientation: Heterosexual, Lesbian (Numbers Not Specified)	Semi-structured Interviews	Qualitative Analysis Informed by Grounded Theory Methods	21%
Rahilly (2018)	To examine parents' assessments of childhood gender nonconformity and the contrast between "just gay" and "truly trans."	Total: 56 Parents Age: 29-60 Years Gender: 45 Females, 11 Males (Including a Transgender Step-father) Race/Ethnicity: 50 White, 3 Latinx, & 3 Biracial (White/African American, White/Latinx, & White/Middle Eastern) Sexual Orientation: Heterosexual & Non-heterosexual (Numbers Not Specified)	Semi-structured Interviews	Grounded Theory	8%
Sansfaçon et al. (2015)	To gain understanding of the issues and challenges experienced by parents of gender-variant children in the process of supporting their children's gender identity and expression while they grow; and to provide these parents with a safe space to discuss their experiences, identify challenges on a personal, social, and political level, and frame direct action-oriented solutions according to their own collaboratively identified goals.	Total: 14 Parents	Group Discussions	Grounded Theory Analysis	46%
Sansfaçon et al. (2020)	To develop a deeper understanding of gender-divers/trans children/youth and their parents/caregivers' experiences of their gender-affirming care setting.	Total: 36 Parents Gender: 32 Female, 4 Males	Semi-structured Interviews & Socio-demographic Questionnaire	Grounded Theory & Thematic Analysis	50%
Schimmel-Bristow et al. (2018)	To describe the journey transgender youth and their families experience during the recognition, coming out, and transition processes, including in the context of their healthcare experiences.	Total: 18 Caregivers Gender: 13 Females, 4 Males, 1 Trans-masculine Race/Ethnicity: 14 White, 1 Black/African American, 1 Indian or Alaska Native, 1 Hispanic/Latino, 1 More Than One Race/Ethnicity	Focus Groups or Interviews	Thematic Analysis	38%
Tyler (2015)	To develop an emergent theory describing the relational process (i.e., the space between parent and child) before and after a child discloses a LGBTQ sexual orientation and/or identity to his or her parent(s); and to broaden the lens of LGBTQ familial research by exploring how macro/societal influences (i.e., policy, prejudice, stigma, and attitudes) play out within the relational process.	Total: 3 Parents Gender: 3 Cisgender Females Race/Ethnicity: 3 Caucasian Sexual Orientation: 3 Heterosexual	Interviews	Grounded Theory	17%

Note. Parents of TGNC children often represented a smaller subsample of a larger sample.

Results

We identified two themes, six subthemes, and 24 findings. *Seeking guidance* is the first theme with the subthemes of educational resources, community networks, and advocacy efforts. This first theme represents parents' efforts to access information and to receive and provide social support. *Seeking healthcare* is the second theme with the subthemes of healthcare providers, mental healthcare, and general healthcare. This second theme represents parents' efforts to access healthcare related to their TGNC children. Findings represent specific elements found in two or more articles associated with a subtheme. For example, parents hesitation to seek healthcare is one finding in the subtheme of *healthcare providers*. We organized the 24 findings in the order of most-to-least prevalence within each subtheme in the paragraphs that follow.

Seeking guidance

Educational resources

Parents found that educating themselves about TGNC identities was helpful. For example, some parents learned about the power of law and its impact on their TGNC children (Sansfaçon et al., 2015) and others reported that gaining knowledge about health risks, e.g., suicidality, moved them quickly toward acceptance (Kuvalanka et al., 2014). Parents sought resources online regarding their child's TGNC gender identity. Many seemed to find online resources beneficial because they allowed for anonymity (Schimmel-Bristow et al., 2018).

Parents spoke of a lack of available information. They seemed frustrated by the limited number of educational resources and the difficulty that resulted when they attempted to educate others about their TGNC child's gender identity. For example, not every parent had access to resources that could help them prepare for their advocacy efforts (Johnson et al., 2014). They educated themselves about their child's potential medical needs. Many seemed to learn about gender-affirming treatment, e.g., puberty blockers, for the first time. For example, parents searched online for gender-related healthcare with options for physically transitioning, often starting with no prior knowledge about the topic of transgender healthcare (Evans et al., 2017).

Community networks

Parents reported benefitting from LGBTQ community affiliations. They seemed appreciative of meeting other parents of TGNC children and the awareness that they were not alone. For example, many made new friends in support groups for LGBTQ individuals and their families (Gonzalez et al., 2013) and found value in connecting with TGNC communities. They reported that community support increased their confidence in their parenting decisions, learning that they were not alone and other parents of TGNC children faced similar challenges (Gray et al., 2016). Parents also sought social support online. These parents appeared to especially benefit from online support from other parents of TGNC children. For example, many developed close friendships via online networks for transgender youth or caregivers of transgender youth (Evans et al., 2017) and connected with other parents of TGNC children (Johnson & Benson, 2014).

Advocacy efforts

Parents provided support by way of advocacy. Many seemed to seek out opportunities to advocate for TGNC individuals, in addition to advocacy for their own children. For example, some joined formal transgender advocacy groups (Kuvalanka et al., 2014), and others worked to develop awareness relating to diverse gender identities among professional medical and mental health community members at healthcare institutions (Johnson & Benson, 2014). Parents of TGNC children described motivations that influenced their individual advocacy efforts. For example, parents seemed motivated to educate their children's school personnel, start support groups, and fight for legislative changes pertinent to transgender rights (Johnson et al., 2014).

For some parents, advocacy represented an opportunity to support families with LGBTQ children. Parents' advocacy efforts seemed to highlight their desire to support other parent-child

Table 2. Findings report

Findings	Articles	Frequency effect size
Theme 1: Seeking guidance		
Subtheme 1.1: Educational resources		
Helpful	Hill & Menvielle (2009); Johnson et al. (2014); Kuvalanka et al. (2014); Menvielle & Hill (2010); Rahilly (2015); Sansfaçon et al. (2015); Sansfaçon et al. (2020); Schimmel-Bristow et al. (2018)	31%
Online	Evans et al. (2017); Johnson et al. (2014); Johnson & Benson (2014); Rahilly (2018); Sansfaçon et al. (2015); Sansfaçon et al. (2020); Schimmel-Bristow et al. (2018)	27%
Lack of information	Clark et al. (2020); Field & Mattson (2016); Johnson et al. (2014); Sansfaçon et al. (2020); Schimmel-Bristow (2018)	19%
Medical needs	Capous-Desyllas & Barron (2017); Clark et al. (2020); Evans et al. (2017); Katz-Wise, Budge, Fugate, et al. (2017)	15%
Subtheme 1.2: Community networks		
LGBTQ community (general)	Alegría (2018); Clark et al. (2020); Gonzalez et al. (2013); Gray et al. (2016); Johnson & Benson (2014); Katz-Wise, Budge, Fugate, et al. (2017); Kuvalanka et al. (2014); Menvielle & Hill (2010); Newcomb et al. (2018); Pyne (2016); Sansfaçon et al. (2020); Schimmel-Bristow et al. (2018); Tyler (2015)	50%
LGBTQ community (online)	Alegría (2018); Clark et al. (2020); Evans et al. (2017); Johnson et al. (2014); Johnson & Benson (2014); Kuvalanka et al. (2014); Menvielle & Hill (2010); Pearlman (2006); Rahilly (2015); Rahilly (2018); Sansfaçon et al. (2015); Sansfaçon et al. (2020)	46%
Subtheme 1.3: Advocacy efforts		
Different types of advocacy	Alegría (2018); Bull & D'Arrigo-Patrick (2018); Capous-Desyllas & Barron (2017); Gonzalez et al. (2013); Hill & Menvielle (2009); Johnson et al. (2014); Johnson & Benson (2014); Kuvalanka et al. (2014); Rahilly (2015); Sansfaçon et al. (2015)	38%
Motivation to advocate	Alegría (2018); Clark et al. (2020); Gray et al. (2016); Johnson et al. (2014); Katz-Wise, Budge, Orovecz et al. (2017); Menvielle & Hill (2010); Rahilly (2015); Sansfaçon et al. (2015); Tyler (2015)	35%
Supporting other LGBTQ children and/or their parents	Clark et al. (2020); Gonzalez et al. (2013); Hill & Menvielle (2009); Johnson et al. (2014); Pearlman (2006); Tyler (2015)	23%
Advocacy with discretion	Rahilly (2015); Sansfaçon et al. (2015); Tyler (2015)	12%
Theme 2: Seeking healthcare		
Subtheme 2.1: Healthcare providers		
What worked (feedback for providers)	Clark et al. (2020); Evans et al. (2017); Gray et al. (2016); Hill & Menvielle (2009); Johnson & Benson (2014); Kuvalanka et al. (2014); Menvielle & Hill (2010); Newcomb et al. (2018); Pyne (2016); Sansfaçon et al. (2020); Schimmel-Bristow et al. (2018)	42%
What did not work (feedback for providers)	Clark et al. (2020); Gray et al. (2016); Gridley et al. (2016); Johnson & Benson (2014); Kuvalanka et al. (2014); Menvielle & Hill (2010); Pyne (2016); Sansfaçon et al. (2020); Schimmel-Bristow et al. (2018)	35%
Challenge to find trained providers	Evans et al. (2017); Gray et al. (2016); Gridley et al. (2016); Johnson et al. (2014); Johnson & Benson (2014); Pyne (2016); Sansfaçon et al. (2015)	27%
Recommendations for providers	Gridley et al. (2016); Kuvalanka et al. (2014); Menvielle & Hill (2010); Newcomb et al. (2018); Schimmel-Bristow et al. (2018)	19%
Services provided online	Clark et al. (2020); Johnson et al. (2014); Menvielle & Hill (2010); Newcomb et al. (2018)	15%
Reasons for seeking healthcare	Clark et al. (2020); Gray et al. (2016); Menvielle & Hill (2010); Sansfaçon et al. (2020)	15%
Hesitant to seek healthcare	Evans et al. (2017); Katz-Wise, Budge, Orovecz et al. (2017); Menvielle & Hill (2010)	12%
Subtheme 2.2: Mental healthcare		
Meeting with mental health providers	Alegría (2018); Bull & D'Arrigo-Patrick (2018); Capous-Desyllas & Barron (2017); Johnson & Benson (2014); Sansfaçon et al. (2020)	19%
Children with mental health concerns	Katz-Wise, Budge, Orovecz et al. (2017); Menvielle & Hill (2010); Sansfaçon et al. (2015); Sansfaçon et al. (2020); Schimmel-Bristow et al. (2018)	19%
Child's mental health concerns intersected with the child's gender identity	Gray et al. (2016); Hidalgo & Chen (2019); Schimmel-Bristow et al. (2018)	12%
Avoided stereotype of child needing treatment	Menvielle & Hill (2010); Pyne (2016); Sansfaçon et al. (2015)	12%
Parents more concerned about their child's mental health than child's gender identity	Gray et al. (2016); Gridley et al. (2016)	8%
Subtheme 2.3: General healthcare		
General recommendations	Gray et al. (2016); Gridley et al. (2016); Johnson et al. (2014); Newcomb et al. (2018); Sansfaçon et al. (2015); Sansfaçon et al. (2020)	23%
Healthcare related barriers	Clark et al. (2020); Gridley et al. (2016); Johnson et al. (2014); Sansfaçon et al. (2015); Sansfaçon et al. (2020)	19%

relationships. For example, parents advised other parents to accept their TGNC children for who they are (Hill & Menvielle, 2009). Some became parental role-models and surrogate figures for other TGNC children (Pearlman, 2006) or started their own hometown PFLAG meetings (Tyler, 2015). PFLAG is an organization with over 400 communities across the United States focused on LGBTQ people and allies supporting and educating one another to affirm LGBTQ identities

(PFLAG, 2021). Parents also spoke about practicing advocacy with discretion. For example, some carefully decided if and when to enact gender literacy with others (Rahilly, 2015).

Seeking Healthcare

Healthcare providers

Parents reported what worked well regarding past experiences with healthcare providers. They seemed to appreciate providers who offered an open and affirming space for dialogue. For example, they valued when a provider had prior experience working with TGNC individuals (Johnson & Benson, 2014), and they felt comfortable discussing their concerns and questions with providers who did not judge them (Sansfaçon et al., 2020). Many also described provider interactions that did not work well. They seemed to view untrained providers less favorably. For example, they described negative experiences with providers who attempted to "fix" their child's gender identity (Gray et al., 2016), used outdated and offensive language (Gridley et al., 2016), or were not well educated regarding how to support families (Johnson & Benson, 2014).

Parents struggled to find trained gender-affirming providers. Potential reasons include providers enforcing patient minimum age requirements, being out-of-network, or simply not accepting insurance (Gridley et al., 2016). Parents seemed daunted by the task of finding provider who understand their child's unique medical needs. For example, some experienced difficulties associated with finding providers confident in administering gender-affirming treatments, e.g., cross-sex hormones and pubertal blockers (Evans et al., 2017). Parents also offered recommendations for healthcare providers to consider. They appeared hopeful that providers could improve services offered to address TGNC individuals' needs. For example, some parents recommended that providers receive education on gender-affirming issues to improve their cultural awareness and gender-affirming competence (Gridley et al., 2016).

Parents accessed online healthcare services. They seemed to value online care as an alternative to in-person appointments. For example, some considered online healthcare services an advantage and a more comfortable option than face-to-face meetings (Menvielle & Hill, 2010). Some parents voiced hesitancy related to seeking healthcare for their child and also seemed anxious to meet with providers. For example, these parents feared the prospect of their child receiving gender-affirming medical treatments (Katz-Wise, Budge, Orovecz et al., 2017).

Mental healthcare

Parents met with mental health providers for themselves, with, and on behalf of their TGNC children. For themselves, parents met with mental health providers to receive assurance that their TGNC child was certain about their emerging identity (Sansfaçon et al., 2020). Parents also seemed motivated to address their TGNC child's mental health concerns. For example, some reported that their TGNC child had mental health concerns, including anxiety, depression, and emotional concerns (Menvielle & Hill, 2010). Parents wanted to avoid the stereotype that their child needed treatment, such as mental health therapy focused on correcting their children's gender identity (Menvielle & Hill, 2010). They refused to find fault in or accept problematization of their child's gender identity (Pyne, 2016). Others preferred that their child not receive medical labels yet allowed their child to receive a diagnosis to access healthcare (Sansfaçon et al., 2015).

Parents believed their child's mental health concerns intersected with the child's gender identity. For example, some said their child suffered suicidal ideation in response to the levels of distress they experienced related to their gender (Schimmel-Bristow et al., 2018). Some viewed their child's mental health concerns as more significant than their child's gender identity related issues, including more than potential side effects from transitioning (Gridley et al., 2016).

General healthcare

Parents offered general recommendations primarily for healthcare systems. Their comments

highlighted the need for interprofessional collaborations to support TGNC families. For example, parents benefited from wraparound services with physicians, psychologists, and social workers working together on their child's healthcare (Johnson et al., 2014). Parents also reported feeling distressed by barriers that they faced when seeking healthcare for their TGNC children. For example, some parents reported that they became responsible for educating staff while obtaining services (Sansfaçon et al., 2015) and some reported that they could not access gender identity healthcare services through their health insurance (Johnson et al., 2014).

Discussion

In this study, we summarized qualitative research studies that addressed the topic of parents seeking support on behalf of their TGNC children, from the parents' perspectives. We produced this report for healthcare providers. The findings of this study highlight the various ways that parents seek guidance from educational sources and other people, advocate for other families with TGNC children, and seek medical and mental healthcare for their TGNC children.

In the introduction section, we mentioned three literature review studies focused on TGNC familial support topics (Sharek et al., 2018; Shields et al., 2012; White & Fontenot, 2019). Shields et al. (2012) found that providers could offer educational interventions to support LGBT parents who sought healthcare for their children. Sharek et al. (2018) found that providers could offer information to help family members accept their transgender family member's transition. White and Fontenot (2019) found that support from providers can result in TGNC individuals' experiencing acceptance, healing, and safety. The results of this metasummary affirm the positive role providers can play in supporting TGNC children and their parents.

Our findings highlight several ways the field of TGNC healthcare succeeds yet can also improve. Parents often make healthcare decisions on behalf of their children and providers must consider strategies to provide services that include TGNC children as well as their parents. Upon discovery, some parents believed that their child's TGNC gender identity was only a phase (e.g., Hill & Menvielle, 2009). Providers will need to consider ways to encourage parents to accept their TGNC child and accept their child's TGNC identity as a part of who they are. Providers may decide to invite parents to a meeting without their child. Doing so may permit parents to share personal feelings they consider too difficult to express in front of their child.

Parents discovered educational resources they considered helpful, yet some initially found a lack of information regarding their child's gender identity (e.g., Field & Mattson, 2016). Providers may consider strategies to make their educational content accessible to parents of TGNC children. Strategies may include providing online resources and reaching out directly to local support groups to provide resources. Connecting with parents who recently gained awareness of their child's TGNC identity will remain an ongoing challenge for providers. Yet providers can support parents by providing parent mentoring programs, in which parents with TGNC children can mentor other parents with children who recently began transitioning. Providers may also consider ways to connect with parents who do not accept their child's TGNC identity, especially non-accepting parents who ignore their TGNC child's needs and whom we know less about because they are less likely to participate in research studies (Wren, 2002).

In addition to seeking education, parents described benefits associated with making social connections within the TGNC community (e.g., Gray et al., 2016). Many parents may have access to local support groups, yet some, especially parents in rural settings, may not. Providers may consider providing both in-person and online support opportunities. Providers my consider supplying educational resources to healthcare professionals who serve rural communities or creating a website with a resource list of affirming providers who live in surrounding areas.

Many parents who received support from providers and TGNC community members desired to support others and advocate for their child and other TGNC individuals. Yet parents may

find the transition from disclosing to others to becoming an advocate a daunting challenge.

For example, parents who want to take on advocacy roles for their TGNC children often create online blogs to share their views and details of their experience with others (Rahilly, 2015). They may face negative online responses from people they know and/or others who disapprove of TGNC identities. Providers could maintain resources that represent both local and national advocacy efforts, e.g., Human Rights Campaign. Making advocacy resources available to parents is a small yet critical strategy providers can employ to support parents' initial advocacy efforts.

Parents appreciated healthcare providers who, though they lacked gender identity-related knowledge, were still open to learning (e.g., Kuvalanka et al., 2014). Providers can acquire education about current evidence-based practices to enhance the services they offer to TGNC clients and remain open to the unique situations that parents of TGNC children may bring to them. Providers can actively listen to parents and include them in their children's healthcare.

Parents valued healthcare providers who welcomed clients with diverse gender identities (e.g., Evans et al., 2017). Providers may decide to welcome TGNC individuals and their family members proactively with inclusive messaging on office signs or healthcare websites. Providers must also ensure that front office staff and other personnel, who interact directly with clients and their families, receive gender identity sensitivity training. Other steps include updating medical record systems to document each client's "sex assigned at birth," "gender identity," "legal name," "affirmed name," and "affirmed pronouns." This strategy increases the likelihood that all personnel will use accurate identifying information linked with each client's gender identity.

Parents struggled to find healthcare providers educated about TGNC issues with office locations close to them (e.g., Gridley et al., 2016). Providers may consider traveling or offering online services to clients in remote locations. Healthcare providers in remote locations may travel to conferences with workshops provided by gender-affirming specialists. Increasing accessibility of TGNC-related services may allow more TGNC clients to receive healthcare.

Some parents mentioned that their children also had mental health issues (e.g., Menvielle & Hill, 2010). Many described their child's mental health issues as intersecting with their gender identity-related concerns, and some even identified their child's mental health issues as more concerning (e.g., Gray et al., 2016). Providers may consider working on interprofessional teams with other healthcare providers to address TGNC children's medical and mental health issues. If a TGNC individual needs a signed letter from a mental health provider before they can medically transition, they may appreciate visiting a clinic with both medical and mental health providers.

Limitations

This qualitative metasummary study includes several limitations. First, the articles represent studies involving parents who primarily had access to healthcare. Some parents described difficulty related to finding gender-affirming trained providers (e.g., Gridley et al., 2016), yet many parents do not have access to health insurance. A future study could explore the experiences of uninsured families who cannot access healthcare. The results of this study may inspire new strategies for including families or creating familial services. Second, some parental responses appeared general in nature, lacking ample specificity regarding which qualifications made for a successful healthcare provider experience. Future studies can further explore how parents rate providers and decide which specific factors matter to them the most.

Third, we reviewed articles only with participants residing in the United States and Canada. Our study's results maintain a lack of generalizability to other countries and continents. Researchers may consider conducting a similar study in other global/geographical areas. Fourth, this study included qualitative findings from parents with TGNC children of various ages, e.g., youth to adulthood. The needs of parents with younger TGNC children differ from the needs of parents of adult TGNC children. For example, the parents of a five-year-old transgender child

maintains more responsibility for providing medical insurance (e.g., Capous-Desyllas & Barron, 2017) than the parents of a financially independent adult TGNC child. Future studies may explore the challenges parents face when supporting TGNC children at specific ages.

Conclusion

This qualitative metasummary introduced several challenges that parents of TGNC children face and opportunities for healthcare providers to address them. Associated with the theme of *seeking guidance*, we found that parents seek resources, build communities, and engage in advocacy in-person and online. Providers can meet the needs of parents in-person and online, especially by offering online services to parents and TGNC children in more rural locations.

Accessibility to healthcare remained a prevalent topic across studies. Providers can employ multiple strategies to make their services accessible, including sharing information with local TGNC and LGBTQ familial support groups. Parents commonly sought support from other parents of TGNC children. Providers may consider sharing their contact information and resources at support groups to make themselves accessible to parents of TGNC children.

We learned that parents tend to know what they do and do not like, as informed by their past interactions with healthcare providers. Associated with the theme of *seeking healthcare*, parents shared their experiences of initial meetings with health providers, including their struggles with meeting providers who lacked gender-affirming training or the necessity to travel far to access providers with training in gender affirming care. Parents seemed to want providers who addressed both the parent-child relationship and the child's medical needs. For example, Hill and Menvielle (2009) found that some parents believed that their child's gender identity was only a phase. Providers will need to consider supportive ways to address this belief and how it can impact parent and TGNC child interpersonal communication.

The subtheme of *mental healthcare* highlighted occurrences of parents wanting their child's mental health needs met without problematization of their child's gender identity. TGNC individuals often experience high rates of traumatic life experiences (Richmond et al., 2017). Providers can offer trauma-informed care that frames mental health concerns as potential reactions to hearing cisgenderist societal messages rather than associated with gender identities.

Related to the subtheme of *general healthcare*, parents' feedback seemed to highlight the need for inclusive messaging available at multiple points of access: professional websites, building entrances, reception desks, and in healthcare providers' offices. Providers can also introduce themselves by sharing and asking for patients' pronouns. This simple step provides an opportunity to leave little doubt to others that they offer gender-affirming care. Parents seemed to appreciate inclusive messaging, even before meetings with healthcare providers.

Parents of TGNC children want multidisciplinary transition-related care (Gridley et al., 2016) and TGNC-related, family-based programming (Newcomb et al., 2018). A salient finding from this metasummary is that parents of TGNC children want healthcare systems with providers who collaboratively serve TGNC families. Therefore, we recommend that healthcare providers collaborate with one another on interprofessional teams to provide effective and accessible services to TGNC children and their accompanying family members, especially parents.

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